

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN9008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/15/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKEBRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 WOODLAWN DRIVE</b> <b>JOHNSON CITY, TN 37604</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the complaint investigations of # 28272, #28317, conducted on July 13, 2011, at Lakebridge Healthcare Center, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

4LJX11

If continuation sheet 1 of 1